Interest

Interest expense related to patient care is an allowable capital cost under Medicare. The interest must be necessary and proper--that is, it must be incurred on a financially necessary loan related to patient care, and it must be obtained from a lender unrelated to the borrower at a rate of interest that does not exceed what a prudent borrower would pay. With some exceptions, however, interest expenses must be reduced by investment income to be considered necessary. For example, consider the hospital that pays $90,000 in interest on a mortgage but earns $10,000 in interest on its money market account. Since the hospital could have used its money market balance to reduce its mortgage, it is recognized as having only $80,000 in necessary interest expense ($90,000 less $10,000). On the other hand, interest expense need not be reduced by investment income from gifts and grants, a provider's qualified pension fund, or funded depreciation (income from savings to replace worn-out capital).

Depreciation

Medicare also reimburses hospitals for depreciation on buildings and equipment "used in the provision of patient care." Because physical assets decline in value as they age and eventually must be replaced, depreciation is recognized as a legitimate cost of doing business. Accordingly, accountants have developed several methods for prorating an asset's cost over its useful life. Generally, Medicare reimburses hospitals according to the straight-line depreciation method under which the annual depreciation cost is constant and equal to the acquisition cost less salvage value divided by the useful life of the asset. In an earlier example, the $1 million cost of the MRI was spread equally across its useful life of 10 years--$100,000 annually in depreciation costs--because its salvage value was assumed to be zero. Medicare reimbursement rules take into account, however, the possibility that the estimate of useful life may be inaccurate. For instance, if the MRI in the example were sold for $500,000 at the end of 10 years, Medicare would "recover" its share of the unexpected profit on the sale. Similarly, if the machine lasted only five years, the hospital could write off the undepreciated value of the MRI at the end of the fifth year.

Return on Equity

Under Medicare's reimbursement rules, proprietary hospitals receive a payment for their investment in the hospital. This payment (called return on equity) is similar to a rate of interest (called a rate of return) applied to the value of the investment. The rate of return is determined by the interest rate paid on the assets of the federal Hospital Insurance Trust Fund. The payment of return on equity to proprietary hospitals has been a subject of continuing controversy since Medicare was enacted in 1965. Most recently, under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), return-on-equity payments to hospitals were reduced by 25 percent in 1987, 50 percent in 1988, and 75 percent in 1989. After 1989, Medicare will not make payments for return on equity. (Unless otherwise noted, return-on-equity payments are excluded from all subsequent calculations in this report.)

Reductions in Payments

The Congress has enacted a series of across-the-board reductions in payments to hospitals for capital-related expenses. Under the Omnibus Reconciliation Act of 1986 (Public Law 99-509), each hospital's reasonable costs were reduced by 3.5 percent in 1987, 7.0 percent in 1988, and 10.0 percent in 1989. The Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) increased these cuts to a total reduction of 12 percent beginning in January 1988 and 15 percent in fiscal year 1989.

Problems under the Current System of Payment

The current system for reimbursing capital has several serious problems:

- Capital-related expenses are not accurately measured, and their correct apportionment to Medicare patients is difficult to determine;
- Hospitals are not encouraged to be economical in purchasing or leasing capital; and

- Medicare's payments for capital are not under federal control.[1]

Inaccurate Measurement of Medicare's Capital Costs. Under cost-based reimbursement, hospitals must estimate total capital-related expenses and then determine Medicare's share. Both steps in this process are subject to a great deal of uncertainty.

Two errors are apt to occur in measuring capital-related expenses, both of which lead to underestimating actual capital costs. First, depreciation expenses are based on historical costs rather than replacement costs. For example, a CAT scanner that cost $400,000 in 1980 might cost $1 million to replace in 1989. Its depreciation cost--based on a 10-year useful life--would be $40,000 in 1989. Alternatively, the depreciation cost calculated on the market cost of buying a new one would be $100,000. The difference between historical and replacement costs, although small in the first year after the investment, increases with each passing year.

Another factor that leads to underestimating capital costs is the way internally financed assets are treated under Medicare's reimbursement rules. If a hospital finances a capital project with its own funds, the hospital's implicit interest costs generally are not included in its cost calculations. If, instead, a hospital invests its internal funds in paper assets, the earnings usually are deducted from its interest costs. Therefore, its true interest costs tend to be underestimated.

Two exceptions must be noted. First, proprietary hospitals receive return-on-equity payments, but payments are to be eliminated after 1989. Second, hospitals are allowed to earn interest on funded depreciation, endowments, and pension assets.

Measuring a hospital's total capital costs is only the first step in determining Medicare's payment for them. The second step is to calculate Medicare's share. Under current regulations, the costs of routine services--that is, room and board--are apportioned on the basis of

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1. The discussion here notwithstanding, cost-based reimbursement does have advantages, especially for the hospital industry. For example, by reducing the risk from undertaking capital projects, cost-based reimbursement may make it easier for hospitals to borrow in financial markets. See Brian Kinkead, *Historical Trends in Hospital Capital Investment*, DHHS Contract No. HHS-100-820038 (Washington, D.C.: Urban Systems Research and Engineering, Inc., July 1984), pp. 22-28.

Medicare's share of total inpatient days, and costs of ancillary services--services other than room and board, and professional services--are apportioned on the basis of Medicare's share of total inpatient charges. These arbitrary accounting rules may not reflect the actual costs of treating Medicare's patients. For one thing, the apportionment rules do not take into account unused capital. Since hospital occupancy rates have been declining since 1981 and are now about 60 percent, Medicare's share would tend to be overstated when compared with the benefit received by patients. (They are correctly stated from the perspective of the hospital, however, since it actually incurred those costs.) The occupancy rate does not, however, immediately lead to an estimate of unused capacity since the unused beds may not be fully staffed or equipped.

Inefficiency. Critics of cost-based reimbursement for capital point out that the current system does not promote efficient investment decisions, in part because it insulates hospitals from the normal risks of business decisions. For example, because interest expense is reimbursed, hospitals may not act prudently--that is, they may not time their investments to periods of low interest rates or seek out the lowest possible interest rate. In addition, capital payments are not contingent on use; hospitals are reimbursed in full for depreciation and interest regardless of the occupancy rate. As a result, they are insulated from the negative effects of acquiring excess capital, such as underutilized facilities.

Yet, some hospitals--such as those with a high level of bad debt and charity care--may be unable to generate sufficient earnings through their operations and thus may be unable to borrow at a reasonable cost. Because the cost of equity financing for nonproprietary hospitals is not reimbursed, the present system provides little support to hospitals that cannot generate capital through loans or by issuing bonds. This lack of funds for necessary capital projects may result in inefficient or low-quality care for Medicare beneficiaries.

Finally, many policymakers are concerned that the PPS, which now pays for operating costs on a prospective basis and capital costs on a retrospective cost basis, encourages hospitals to operate inefficiently. In essence, the system creates an incentive for hospitals to favor capital expenditures--particularly those that lower operating costs--or

to substitute capital for operating expenses, even if the net effect is to raise total costs.

Of course, these incentives are strictly true only for the Medicare portion--about 40 percent--of hospital business. To the extent that hospitals are not reimbursed in this way by other payers, inefficient incentives are reduced.

Lack of Budget Control. Under cost-based reimbursement, individual hospitals decide how much capital to purchase and, ultimately, how much will be reimbursed for capital costs. However, since payments for capital are not closely related to services delivered, they could grow more rapidly than suggested by growth in admissions or the prices of other goods and services purchased by hospitals. This outcome is especially likely if hospitals respond to the incentives in the current law by substituting capital for labor.

In contrast, Medicare payments on the operating side are much more controllable because payment is limited to a fixed amount per case. Total payment for operating costs grows only to the extent that the amount per case increases, the total number of patients discharged increases, or the complexity of patients' ailments increases.

CHAPTER II

IMPLICATIONS OF INCLUDING CAPITAL PAYMENTS IN THE PPS

Moving from a cost-based reimbursement system for capital to a prospective one entails, among other things, making a trade-off between efficiency and stability for the hospital industry. On the one hand, prospective payment for capital would generally encourage the hospital industry to make more efficient use of capital and would, therefore, have the potential to reduce future expenditures for capital by Medicare and other payers. Moreover, the sooner a new system is established, the sooner these gains would be realized.

On the other hand, carrying out prospective payment immediately would create--at least in the short run--windfall gains for some hospitals and windfall losses for others. Unfortunately, it is not possible to quantify either the short-run or long-run gains in efficiency that would result from adopting a prospective payment system for capital. For that reason, this analysis is limited to the possible magnitude of hospitals' windfall gains and losses, as well as how quickly hospitals would be able to adjust to a new reimbursement system.

IS PROSPECTIVE PAYMENT FOR CAPITAL A GOOD IDEA?

Incorporating capital costs into an expanded PPS would deal with two major problems associated with cost-based reimbursement--inefficiency and lack of budget control. Since Medicare payments would be based on the number of patients discharged rather than the costs of treatment, any reductions a hospital decides to make in its capital spending would not lower its reimbursement from Medicare. For this reason, hospitals would probably make more efficient use of capital under the PPS. Moreover, the Medicare program would be better able to control payments for capital under an expanded PPS. The savings from prospective payment could go to Medicare beneficiaries, hospitals, or the federal treasury.

Including capital costs in the PPS would, however, have several disadvantages. For one thing, Medicare payments for capital would no longer rise and fall with capital costs. As a result, when a hospital's capital stock was old--meaning it had low capital costs--the hospital would have to save the excess payments to finance future renovations. Some hospitals might be unwilling or unable to do this. Furthermore, many lenders might be less willing to lend funds for new hospital projects under a system in which payments were not related to capital costs.

Even if most hospitals could eventually adjust to the new system in the long run, some hospitals would experience large percentage short-run windfall gains or losses in their reimbursements for capital costs. These changes would be closely related to whether a hospital was at a low or at a high stage of the capital cost cycle. Hospitals with low capital costs--and therefore large gains from PPS--could save their excess payments for the time when their costs would be larger than the PPS payments. Hospitals with large losses in capital payments--which would have had no such chance to save from previous excess PPS payments--might be forced to close in extreme cases.

Some hospital administrators might object to prospective payment--especially if applied to capital investments made under cost-based reimbursement--on grounds of fairness. They would argue that their high capital costs are the result of contracts entered into in good faith based on Medicare regulations in effect long before the advent of PPS. They would argue, furthermore, that the windfall gains of other hospitals would not be directly related to any additional services for Medicare beneficiaries.

Another, less-publicized problem of including capital in the PPS is that doing so would reinforce the weaknesses of the current PPS. The current system creates incentives for hospitals to avoid treating certain patients with complicated conditions and to discharge patients earlier than medically desirable--referred to in the popular press as "dumping" and as discharging patients "quicker and sicker." This incentive results from hospitals receiving little or no additional payments for treating especially complicated cases.[1] Expanding the PPS

1. Research on this type of behavior has not convincingly shown that the PPS lowers quality of care. For a survey of the evidence, see Health Care Financing Administration, *Impact of the Medicare*

would only exacerbate whatever tendencies hospitals may have toward these undesirable actions. Under the current system, a hospital with an especially complicated case receives additional payments for capital costs that were roughly proportional to the additional services performed. If capital costs were incorporated in PPS and capital payments costs were fixed for a given DRG (diagnosis related group), hospitals would have more incentive to avoid complicated cases.

Finally, cost-based and prospective reimbursement have one problem in common: no one knows for sure how much Medicare should pay hospitals for capital-related expenses. To set the initial prospective payment level for operating costs--known as the standardized amount--the current PPS used average historical costs. If this approach were used to set the prospective payment for capital, it would be subject to the same measurement and apportionment problems that plague cost-based reimbursement. The alternative--to base the prospective payment on how much would be needed to provide for the optimal amount of capital in the future--presents even greater estimation and measurement problems that could only be resolved after a substantial effort in data collection and research.

HOW FAST COULD HOSPITALS ADJUST TO PROSPECTIVE PAYMENT FOR CAPITAL?

A couple of simple examples will indicate the possible magnitude of changes in payments for capital costs for certain hospitals. A recently renovated hospital--that might have received $1,200 per case under cost reimbursement--might receive $400 per case under the new system. The reduction of $800 per case, or two-thirds of its capital costs, would represent approximately 17 percent of the hospital's total payments from Medicare, or roughly 7 percent of its entire budget for inpatient services if its other characteristics were typical. The financial effect could be larger or smaller depending on whether the hospital had more or less than the average proportion of Medicare patients, or a higher or lower ratio of capital to operating costs.

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care Hospital Prospective Payment System, 1985 Annual Report, HCFA Publication Number 03251 (Washington, D.C.: U.S. Department of Health and Human Services, August 1987).

On the other hand, a hospital with a somewhat older physical plant might have costs of $100 per case. The same prospective payment of $400 per case--representing an unexpected windfall of 300 percent in capital payments--might translate into 8 percent more total payments from Medicare, or a gain of about 3 percent of the entire hospital's inpatient budget. Again, the financial effect could be larger or smaller, depending on whether the hospital had more or less than the average proportion of Medicare patients, or a higher or lower ratio of capital to operating costs.

Whether changes of this magnitude would substantially alter the short-run financial picture for a hospital would depend on many factors. Certainly, some hospitals that are on the edge of bankruptcy might close because of a small loss under prospective payment, or alternatively, might be saved from bankruptcy by a small gain. At the same time, hospitals with large endowments or good financial ratings could survive large reductions in Medicare's payments. Other hospitals might go out of business even if they received large windfall gains from Medicare, especially considering the excess capacity that now exists in the hospital industry.

Moreover, these short-run gains and losses from capital costs being immediately included in the PPS must be assessed in the context of the capital cycle. Because capital costs for each hospital tend to decline with the age of physical plant and equipment, hospitals receiving less under prospective payment would tend to be those with recent renovations or expansions. In the years following inclusion of capital costs in the PPS, these hospitals would find their financial situation improving as their debts were retired and interest payments fell. Similarly, hospitals with windfall gains under prospective payment would probably be those with an older plant and equipment. Although their windfall gains would not be directly related to any additional services for Medicare beneficiaries, they could save the excess payments to replace worn-out buildings and equipment in the future; this would be, in fact, the intent of any system that pays for capital prospectively.

A complete analysis of the effects of immediate inclusion would have to take into account the behavioral responses of hospitals. Because hospitals under prospective payment would have incentives to be more economical in their use of capital, any analysis that does not capture these behavioral changes would tend to overstate the re-

ductions in payment and understate the gains. To the extent that hospitals would be able to adjust their capital expenses in response to a change in reimbursement, the analysis of short-run gains and losses under prospective payment overestimates the number of losers and the amount of their losses. Furthermore, if hospitals were to reduce costs, a system that was designed to be budget neutral might actually increase the profit margins of hospitals compared with cost-based reimbursement.

This type of adjustment actually took place under the PPS for operating costs, when hospitals promptly responded to the new payment rules. As a result, hospitals' operating costs grew more slowly than expected and profit margins increased under the PPS, especially during its first year.

Whether hospitals would adjust their capital spending to a new payment system as quickly as they did their operating costs is not readily apparent. Some capital goods--such as land and buildings--represent long-term commitments. For example, a hospital that wants a 25 percent smaller physical plant may wait 15 years (until the current one wears out) to build a new, smaller facility. Sometimes physical assets can be sold, but usually at much less than book value. Alternatively, unused space may be converted--at some additional cost--to uses other than inpatient care. In contrast, the costs of movable equipment--for example, X-ray machines and wheelchairs--can be adjusted faster because their expected lifetimes are generally shorter compared with plant and fixed equipment. Because of this difference between fixed and movable capital, adjustment to prospective payment might start quickly but continue over many years.

For the short run, hospitals could more easily reduce operating costs than they could capital spending. For example, they can lay off nurses and other hospital personnel, and can purchase lower-cost supplies as the current inventory is depleted. Although hospitals have some contracts with personnel and suppliers, they seldom exceed one year in duration. On the other hand, interest payments--representing about 40 percent of capital costs--might be reduced if capital were included in the PPS. Hospitals would have much stronger incentives to reduce interest costs--by refinancing at lower interest rates--under PPS compared with cost-based reimbursement. Of course, they would

have the opportunity to do so only if current interest rates were lower than those that prevailed when their loans were made.

A couple of alternative views of the relative length of capital and operating cycles are also plausible. For example, the early obsolescence of equipment and the need to maintain physical plants mean that the average effective life for hospital inpatient capital is quite short. Although hospital buildings may last many years, they require frequent major renovations to keep up with changes in technology and medical practice.

Another view of the operating cycle is that the use of personnel and supplies is closely related to the amount of physical plant and equipment. According to this view, because reductions in operating costs require major alterations in physical plant and equipment, capital and operating costs have closely related cycles.

Whether the experience of operating costs under the PPS would also be true for capital costs depends on which view of capital and operating cycles is correct. In any case, the possibility that capital costs would adjust quickly to a new payment system cannot be ruled out.

WHAT WOULD BE THE INITIAL EFFECTS OF IMMEDIATELY INCLUDING CAPITAL IN THE PPS?

To quantify the immediate effects of including capital costs in the PPS, a hypothetical PPS must be designed. The analysis in this chapter is structured the same way as payments for operating costs under the PPS, which are described in the Appendix. Standardized amounts for capital costs were computed separately for urban and rural hospitals so that each group would receive the same total amount as under cost-based reimbursement. These standardized amounts were adjusted for case complexity, for the high costs of patient care in hospitals with teaching programs or with higher proportions of low-income patients, as well as for "outliers"--that is, cases with extraordinarily high costs. These adjustments were based on the same formulas used in the current PPS for operating costs.

If capital costs were actually folded into the PPS, all of the adjustments would have to be reestimated because the current ones were calculated based on operating costs only. For example, the effects on capital costs of the ratio of the number of residents to the number of beds--the indirect teaching adjustment for capital--might be greater or less than that for operating costs alone. Such a carefully designed system based on an extensive study of factors affecting capital costs would almost certainly produce smaller differences between cost-based and prospective payment compared with the simpler approach taken in this study.

The initial effects of immediately including capital in the PPS were estimated from a simulation, based on 1984 data, of hospitals' experience under the illustrative system. If the prospective payments for capital were designed to be budget neutral--that is, if the average Medicare payments for capital costs were the same as under cost-based reimbursement--more than 60 percent of all hospitals would have received higher Medicare payments for capital in 1984 than they actually did (see the middle panel of Figure 4). More than half of all hospitals would have received at least 20 percent more under prospective payment than under cost-based reimbursement, and more than one-third of hospitals would have received at least 50 percent more.

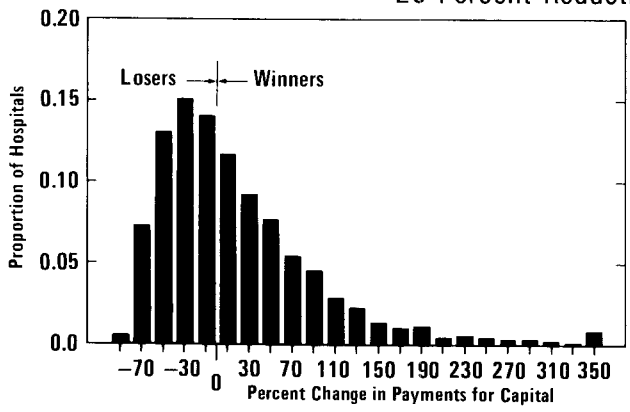
The new system, of course, would have produced losers as well as winners. Under budget neutrality, 37 percent of all hospitals would have received lower prospective payments for capital compared with actual 1984 Medicare payments. Almost one hospital in four would have received at least 20 percent less, and about one in 11 hospitals would have received less than half of their actual reimbursements under the cost-based system.

The 1984 level of payments for capital costs was not, however, necessarily based on the optimal amount of investment in the hospital industry. Because the incentives under cost-based reimbursement would lead to too much capital, the appropriate amount of hospital inpatient capital would result in lower capital costs. In 1989, based on the reductions under current law, Medicare's capital payments will be 15 percent lower than actual capital costs. Thus, a budget neutral prospective system established that year or later would automatically provide less funding for capital than the illustrative system examined

Figure 4.

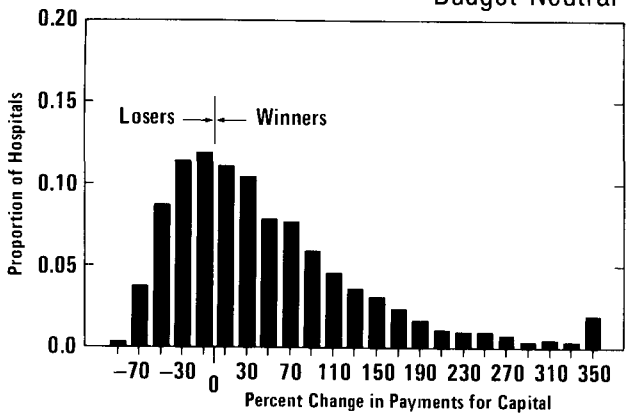
Changes in Capital Payments (Prospective payment compared with current law)

20 Percent Reduction



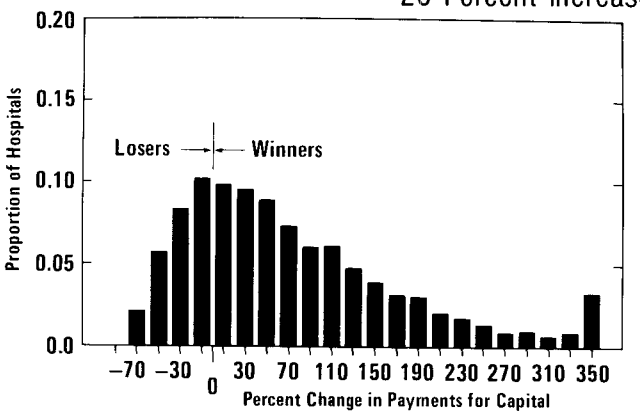
GAINS:	
More than 50 percent	24.5
More than 20 percent	37.3
Any gain	48.7
LOSSES:	
More than 50 percent	15.4
More than 20 percent	37.4
Any loss	51.3

Budget Neutral



GAINS:	
More than 50 percent	37.3
More than 20 percent	51.6
Any gain	62.6
LOSSES:	
More than 50 percent	8.9
More than 20 percent	25.6
Any loss	37.4

20 Percent Increase



GAINS:	
More than 50 percent	48.7
More than 20 percent	62.6
Any gain	72.3
LOSSES:	
More than 50 percent	5.3
More than 20 percent	17.7
Any loss	27.7

SOURCE: Congressional Budget Office calculations based on the 1984 Medicare hospital cost report file.
NOTE: The top interval includes all hospitals with gains greater than 340 percent. The bottom interval includes all hospitals with losses greater than or equal to 80 percent.

here for 1984. There is no way, however, to judge if this is the appropriate reduction.

Moreover, higher or lower payments for capital would be appropriate if demographic or technological changes could be expected to drastically increase or decrease the future needs for hospital inpatient services. But lacking conclusive information on the appropriate level of investment, this study analyzed the effects of immediate implementation under a 20 percent budgetary reduction and a 20 percent budgetary increase.

Setting total prospective payments for immediate implementation at 20 percent less than actual 1984 payments would have reduced the proportion of hospitals receiving more than they would have under cost reimbursement and increased the proportion getting less (see the top panel of Figure 4). Less than half of all hospitals would have received higher payments under immediate implementation, and roughly 15 percent of hospitals would have received less than half of their actual Medicare capital payments.

Under the less likely scenario of immediately carrying out higher total prospective payments for capital, the reverse would have occurred (see the bottom panel of Figure 4). More than 70 percent of all hospitals would have received higher payments in the case of immediate implementation compared with cost-based reimbursement. Only about one hospital in 20 would have received prospective payments that were less than half of their payments under cost-based reimbursement. Note, however, that the losses under prospective payment should not be confused with unreimbursed cash outlays. For example, the hypothetical hospital in Chapter I had capital costs of $200,000 in the first year, but its cash outlays were only $162,745.

HOW WOULD PROSPECTIVE PAYMENT FOR CAPITAL COMPARE WITH PROSPECTIVE PAYMENT FOR OPERATING COSTS?

The change in reimbursement in 1984 that would have resulted from including capital costs in the PPS--if hospitals did not change their

behavior--is modest compared with the change that would have been caused by paying prospectively at the full national rate for operating costs in 1984. The change in payments for capital costs--measured absolutely or as a percentage of total Medicare payments--would generally have been smaller than the corresponding change in payments for operating costs.

To assess the relative magnitude of the two policies--immediately carrying out prospective payment for capital costs and immediately carrying out prospective payment for operating costs--the illustrative PPS in the previous section was used. Hospital capital payments under cost-based and prospective reimbursement were determined by the same method as in the above section.

Since the PPS for operating costs was enacted in 1983 and hospitals were already under it in 1984, estimating payments for operating costs is more complicated. Medicare's 1984 payments for operating costs were based on each hospital's 1982 payments inflated to fiscal year 1984. Similarly, to be consistent with the illustrative PPS, prospective payments for operating costs in 1984 were determined according to 1988 regulations.

Payments under this illustrative PPS for capital and for operating costs were compared with estimated payments under a cost-based reimbursement system. The results are shown in Figure 5. Figure 5(a)--comparable to the figure in the middle panel of Figure 4--shows gains and losses in capital payments expressed as a percent of capital payments. As discussed in the previous section, more than 60 percent of all hospitals would have gained under prospective payment. Figure 5(b) shows that about 60 percent of all hospitals would have gained under immediate prospective payment for operating costs. On the other hand, the magnitude of gains and losses in capital payments--expressed as a percent of capital payments--would generally have been larger than the percentage gains or losses in operating payments. For example, half of all hospitals would have had changes (gains or losses) in capital payments greater than 40 percent compared with only one in seven hospitals that would have had changes in operating payments that large.

The absolute magnitude of the gains and losses in payments for capital costs, however, would generally have been small compared

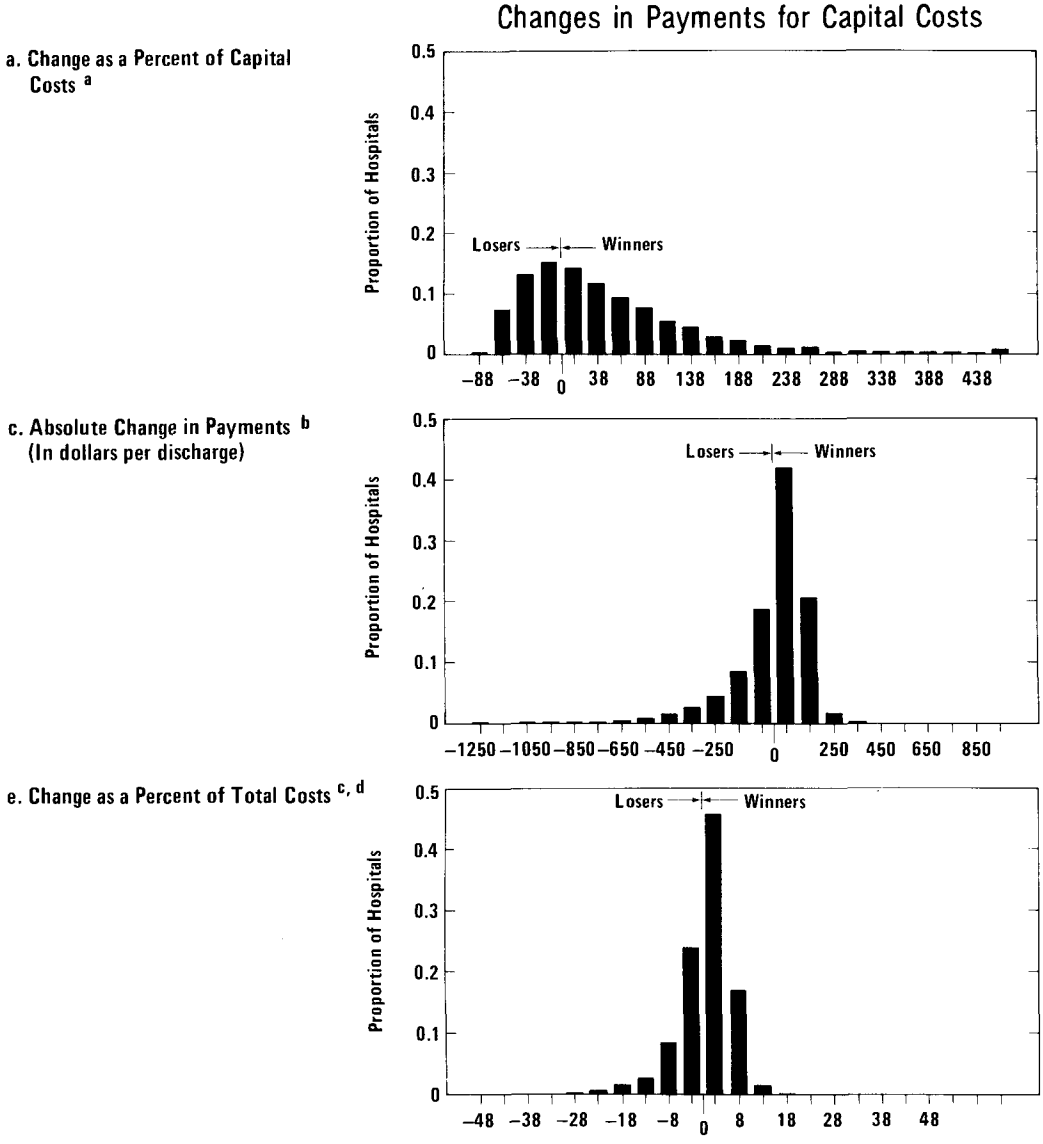
with those for operating costs. Figure 5(c) indicates that most hospitals would have had gains and losses in capital payments that were not very large (as measured in 1984 dollars per discharge). For example, only one hospital in 13 would have had changes in payments greater than $200 per discharge. Figure 5(d), however, shows that changes in payments for operating costs would frequently have been large. For example, two-thirds of hospitals would have had changes in payments for operating costs that were $200 or more for each patient discharged.

The size of gains and losses relative to Medicare's total payments (that is, for both capital and operating costs) would have been smaller if capital costs had been immediately included in the PPS than it would have been if operating costs had been immediately included. For example, only about one hospital in 200 would have gained or lost 20 percent or more of total payments if capital had been included in PPS compared with more than one in three that would have gained or lost an equivalent amount from operating costs being paid immediately under PPS. In fact, more than two-thirds of all hospitals would have had a gain or loss in capital payments that would have been smaller than 5 percent of total payments (compared with less than one in five on the operating side).

These results do not directly address the issue of whether or not hospitals would be able to adjust immediately to prospective payment for capital. First, the change in payments is not comparable to what happened to operating costs under PPS, where payments were only partly based on federal rates in 1984. For this reason, changes under the illustrative PPS are probably much larger than was typical during the first year of PPS. Second, capital costs, by nature, may not be comparable to operating costs. Although the changes in capital payments would be small compared with those for operating costs, that does not necessarily imply that the adjustment would be easier.

These results should be further tempered by two limitations of this analysis. First, the adjustments under PPS--for example, the one for the indirect costs of patient care associated with medical education--were designed for operating rather than capital costs. Therefore, the analysis tends to make capital payments under PPS appear more disruptive than they might be if these adjustments were based on capital costs. Second, the analysis does not account for the positive

Figure 5.
Changes in Payments Under PPS for Capital and PPS for Operating Costs

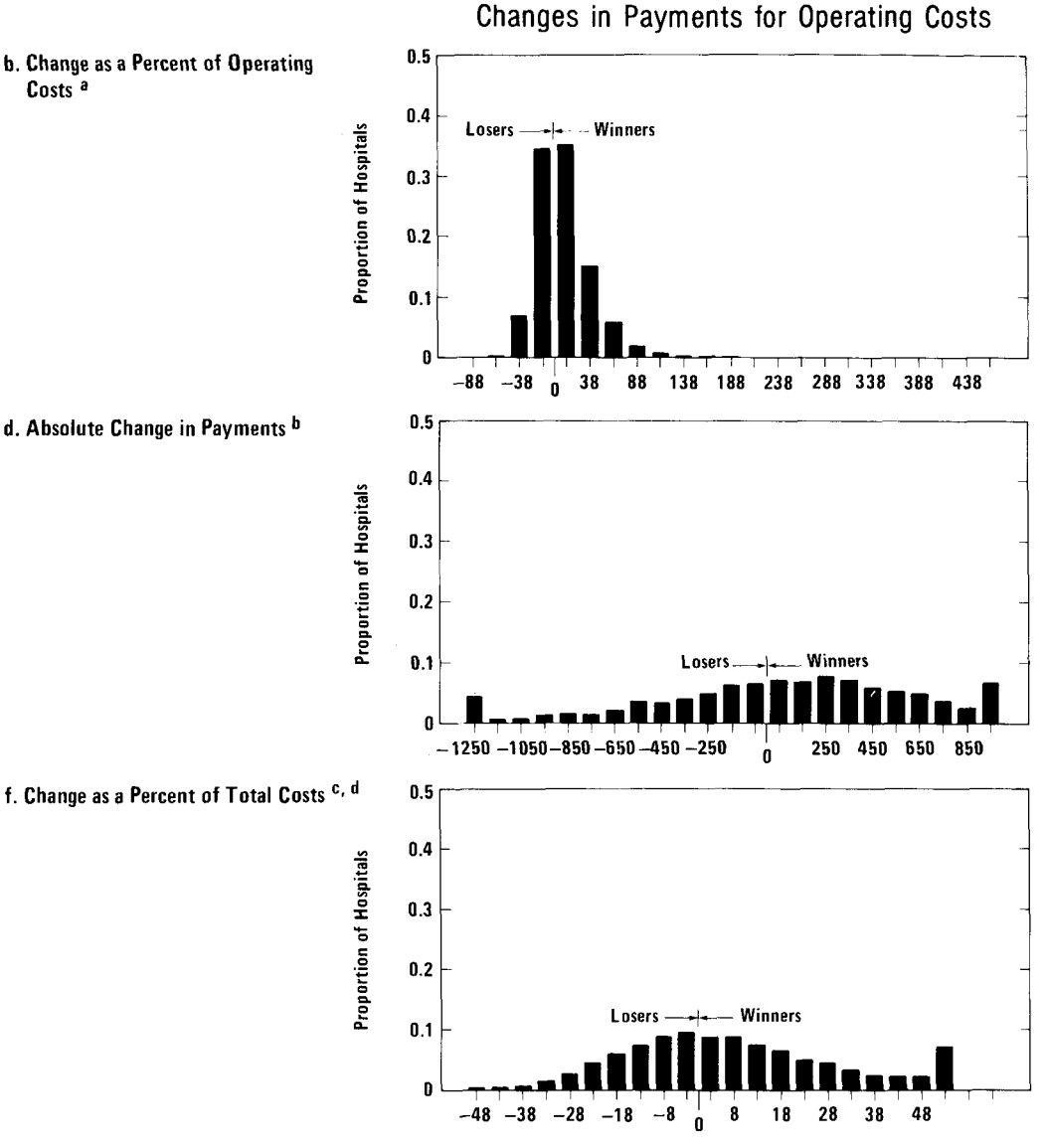


SOURCE: Congressional Budget Office calculations based on the 1984 Medicare hospital cost report file.

[a] The top interval includes all hospitals with gains greater than 450 percent. The bottom interval includes all hospitals with losses greater than or equal to 75 percent.

[b] The top interval includes all hospitals with gains greater than $900 per case. The bottom interval includes all hospitals with losses greater than or equal to $1,200 per case.

Figure 5. (continued)



[c] The top interval includes all hospitals with gains greater than 50 percent. The bottom interval includes all hospitals with losses greater than or equal to 45 percent.

[d] Total costs are the sum of operating and capital costs.

relationship between gains and losses on the capital and operating components of PPS. For example, hospitals that would have lost payments for capital costs would have lost about $180, on average, in payments for operating costs.

CHAPTER III

GENERAL OPTIONS FOR A TRANSITION POLICY

Although a majority of hospitals would do comparatively well under a PPS for capital, the large losses from immediately including capital costs in the PPS for at least some hospitals might pose a serious dilemma. The choices are to continue with cost-based reimbursement despite its drawbacks, to go ahead with PPS for capital despite any disruption it would cause in the hospital industry, or to proceed with it but provide relief to hospitals that would lose under the new system.

The first option is inconsistent with the intent of the Congress as expressed in the Social Security Amendments of 1983. The second option would, of course, have all the advantages and disadvantages discussed in Chapter II. The third choice--establishing prospective payment for capital costs with some type of transition policy--represents a trade-off between immediate PPS and cost-based reimbursement. The Congress must decide whether or not the relief to certain hospitals from such a transition policy outweighs the loss in efficiency from postponing fully prospective payment.

GOALS FOR A TRANSITION POLICY

One reason for the interest in a transition policy is clearly that some hospitals might be seriously hurt by an unfavorable change in payments for capital-related expenses. Policymakers have additional concerns regarding fairness, efficiency, and fiscal responsibility. In fact, a list of major objectives would include:

- *Effective Targeting*: see that help is given only to those hospitals whose long-run financial health is threatened by an unfavorable change in payments for capital;

- *Efficiency*: minimize incentives that lead to the inefficient use of capital;
- *Fairness:* treat similar hospitals similarly; and
- *Fiscal Responsibility*: pay as little as possible for the transition policy.

Effective Targeting

Including capital costs in the PPS would cause serious financial problems for some hospitals that otherwise would have had no problems, or at least more manageable ones. Effective targeting implies that relief would be given to these hospitals but none of the others. It also implies that each hospital would get just the right amount of relief.

Effective targeting is probably the most important goal for a transition policy. In fact, for reasons described below, such a policy would probably also meet the goals for fairness and fiscal responsibility.

Efficiency

If certain hospitals are relieved of the negative financial effects of immediately incorporating capital expenses in the PPS, they might continue to use too much capital. Therefore, an important goal for any transition policy is to minimize the disincentives associated with cost-based reimbursement. Under an ideal policy, hospitals would have the same incentives as they would if capital costs were immediately included in the PPS.

The goal of efficiency also interacts with that of effective targeting. A transition policy may help the right hospitals--effective targeting--but it could also encourage them to overinvest in capital. In other words, a policy of helping no one might promote the right incentives, but it would not succeed in targeting effectively.

Fairness

Usually a policy is considered to be unfair if individuals in similar circumstances are not treated similarly. The corresponding goal for hospitals is that a transition policy should provide about the same amount of relief for similar hospitals. The definition of similar, however, is not at all obvious. Hospitals may be similar in one respect, but quite different when compared in other areas. For example, two hospitals may have the same capital expenses in 1989, but very different needs for capital in the future.

Fiscal Responsibility

According to CBO's February 1988 Annual Report, the federal deficit is projected to be $176 billion in 1989, or about 3.5 percent of GNP. Especially under these circumstances, an important goal for federal health policy is fiscal responsibility. If two transition policies are equivalent in other aspects, then the one that costs the least would be preferred.

This goal, of course, is closely related to effective targeting and efficiency. For example, fiscal responsibility conflicts with the goal of helping every hospital that would get lower payments under prospective payment, but it supports the goal of providing help only to those hospitals that would not survive without it. Limiting relief to a small number of hospitals would greatly reduce the budgetary impact. On the other hand, the obvious budget solution--no relief for any hospitals--conflicts with the goal of helping hospitals that would face severe consequences from a new payment policy, but would emphasize the increased efficiency of prospective payment.

Even a well-defined list of goals at best provides only rough guidance in evaluating the various transition devices. The goals not only conflict with each other, but they may also be difficult to apply in practice. The choice of a transition device depends critically on the importance of competing goals.

ISSUES IN DESIGNING A TRANSITION POLICY

If the Congress were to establish prospective payment for capital costs, it could choose from any number of alternative transition policies, all of which would provide relief to some or all hospitals whose reimbursements would decline under PPS. The Congress would have to resolve four issues, however, under any transition policy:

- Which hospitals would get relief from losses under prospective payment?
- How much relief would each hospital get?
- When would the transition end?
- Would the relief for losers be paid from the federal general fund or from lower payments to other hospitals?

Deciding which hospitals would get relief and how much should be given is difficult for two reasons. First, no hard and fast rules govern how large a loss any hospital could sustain. Second, offering complete relief for all losses above some specified amount would provide inefficient economic incentives to hospitals with losses above that level. For this reason, many transition policies currently being considered would provide only partial relief.

The choice of when to end the transition and fully incorporate capital costs into the PPS could be based on how long it would take hospitals to adjust to a new payment system. The answer to that question, in turn, relates to how fast the current capital stock depreciates. Moreover, the appropriate adjustment period would be longer if a substantial planning period exists. For example, if a major capital project lasts for 20 years and requires five years to plan and execute, then the replacement facility based on the new payment policy might be as long as 25 years in the future. On the other hand, the transition policy could be based on the average, rather than the maximum, replacement period. Furthermore, an additional downward adjustment could be made for the amount of time since the PPS for operating costs was enacted. This approach could be justified on the grounds that, at the